OFFICE OF THE
DISTRICT ATTORNEY
ORANGE COUNTY, CALIFORNIA
TODD SPITZER

June 16, 2022

Sheriff Don Barnes
Orange County Sheriff's Department
550 N. Flower Street
Santa Ana, CA 92703

Re: Custodial Death on March 9, 2021
Death of Inmate Tomas Chavandocarlos
District Attorney Investigations Case # 21-000982
Orange County Sheriff's Department Case # 20-029133
Orange County Crime Laboratory Case # FR 21-43790

Dear Sheriff Barnes,

Please accept this letter detailing the Orange County District Attorney's (OCDA) Office's investigation and legal conclusion in connection with the above-listed incident involving the March 9, 2021 custodial death of 65-year-old inmate Tomas Chavandocarlos.

OVERVIEW

This letter contains a description of the scope and the legal conclusions resulting from the OCDA's investigation of the custodial death of Tomas Chavandocarlos. In this letter, the OCDA describes the criminal investigative methodology employed, evidence examined, witnesses interviewed, facts discovered, and the legal principles applied to review the conduct of any Orange County Sheriff's Department (OCSD) personnel or any other person under the supervision of the OCSD in connection with this custodial death incident.

On March 25, 2021, OCDA Special Assignment Unit (OCDASAU) Investigators were contacted about the death of Tomas Chavandocarlos, who died at the Country Villa Plaza Convalescent Center facility on March 9, 2021 as a result of injuries sustained from a suicide attempt on September 2, 2020 while in custody of the Orange County Men's Central Jail facility located at 550 North Flower Street, Santa Ana, CA, 92703. Chavandocarlos was no longer in OCSD custody

when he died. During the course of this investigation, the OCDASAU reviewed video surveillance footage of Chavandocarlos' attempted suicide, interviewed a witness, as well as obtained and reviewed reports from the OCSD and Orange County Crime Laboratory (OCCL), interviews of witnesses, incident scene photographs, and other relevant materials.

The OCDA conducted an independent and thorough investigation of the facts and circumstances of this event and impartially reviewed all evidence and applicable legal standards. The scope and findings of this review are expressly limited to determining whether any criminal conduct occurred on the part of OCSD personnel or any other person under the supervision of the OCSD. The OCDA will not be addressing policy, training, tactics, or civil liability.

INVESTIGATIVE METHODOLOGY

Among other duties, the OCDASAU is responsible for investigating custodial deaths within Orange County when an individual dies while in custody. An OCDASAU Investigator is assigned as a case agent and is supported by other OCDASAU Investigators, as well as Investigators from other OCDA units.

Six Investigators are assigned to the OCDASAU on a full-time basis. There are additional OCDA Investigators assigned to other units in the Office trained to assist when needed. On average, eight Investigators respond to an incident within an hour of being called. The Investigators assigned to respond to an incident perform a variety of investigative functions that include witness interviews, scene processing, evidence collection, and hospital investigative responsibilities as needed. The OCDASAU audio records all interviews, and the OCCL processes all physical evidence related to the investigation.

When the OCDASAU Investigator has concluded the investigation, the file is turned over to an experienced deputy district attorney for legal review. Deputy district attorneys from the Homicide, TARGET/Gangs, and Special Prosecutions Units review fatal and non-fatal officer-involved shootings and custodial death cases, and determine whether criminal charges are appropriate. Throughout the review process, the assigned prosecutor will be in consultation with the Assistant District Attorney supervising the Special Prosecutions Unit of the OCDA, who will eventually review any legal conclusions and resulting memos. The case may often be reviewed by several experienced prosecutors and their supervisors. The District Attorney personally reviews all officer involved shootings and custodial death letters. If necessary, the reviewing prosecutor may send the case back for further investigation.

DISCLOSURE OF OFFICER-INVOLVED SHOOTING VIDEO & AUDIO EVIDENCE

The OCDA recognizes that releasing video and audio evidence of officer-involved shooting and custodial death incidents can assist the public in understanding how and why these incidents occur, increase accountability, and build public trust in law enforcement. Consistent with the OCDA's written policy in connection with the release of video and audio evidence relating to officer-involved shooting and custodial death incidents where it is legally appropriate to do so, the OCDA is releasing to the public video/audio evidence in connection with this case. The relevant video/audio evidence is available on the OCDA webpage: http://orangecountyda.org/reports/videoandaudio/default.asp.

FACTS

On July 9, 2020, the Santa Ana Police Department (SAPD) arrested Tomas Chavandocarlos for a variety of child sexual abuse crimes, including sexual penetration with a child 10 years or younger (in violation of 288.7(b) PC), continuous sexual abuse of a child (in violation of 288.5(a) PC), and lewd or lascivious act with a minor under 14 years of age (in violation of 288(a) PC), and booked him into the Orange County Central Jail facility on July 10, 2020, located at 550 North Flower Street, Santa Ana, CA, 92703.

During the booking process, Orange County Health Care Agency (OCHCA) medical and mental health professionals screened Chavandocarlos. During his screening, the booking officer observed that Chavandocarlos did not make any statements or exhibit any behaviors indicting he wanted to hurt himself. Chavandocarlos indicated on his screening questionnaire that he had never had ideations or attempts of self-harm or killing himself, and did not indicate that he currently wanted to hurt or kill himself. Chavandocarlos further did not indicate any abnormal behavior or thought processes or any emotional attributes that were inappropriate to the situation. Chavandocarlos also stated that he did not have any preexisting medical or mental health conditions. Additionally, Chavandocarlos indicated that he was not taking and never took any prescription medication.

Chavandocarlos did not answer a question that asked for a yes or no answer asking if he wanted to kill himself. Chavandocarlos also left questions blank that asked for yes or no answers about his tobacco history, if he had recently had a fever/chills/body aches, if he had a cough, runny nose, or congestion, and if his experience was causing significant distress or impairment in his life.

While in custody, OCHCA staff monitored Chavandocarlos frequently. Chavandocarlos made six requests to see OCHCA staff about medical concerns by submitting an "Inmate Health Message" slip, which had various boxes to check that an inmate had concerns about. One of these boxes was for suicide, which Chavandocarlos never checked. Chavandocarlos also never checked boxes for other mental health concerns such as depression or anxiety. Over the two months he was in OCSD custody, OCHCA responded to and treated each of the complaints that Chavandocarlos submitted, including those of headache, back pain, skin rash, and toothache. They also performed one dental procedure and provided him with eyeglasses per his request.

On Wednesday, September 2, 2020, at approximately 4:15 a.m., Orange County Sheriff's Department (OCSD) deputies at the Orange County Central Jail facility opened the Module A Tank Five (5) jail cell doors, which housed inmates that included Chavandocarlos. Chavandocarlos and his fellow Module A Tank Five (5) inmates subsequently went up to and lined up on the walkway in front of Tank Six (6) for sack lunch distribution.

Tank Six (6) was located directly above Tank Five (5), with a raised metal hand railing bordering the Tank Six (6) walkway. An OCSD deputy then began distributing sack lunches to the inmates, who had their backs facing each other with the metal railing to their left. Chavandocarlos was the last person in the line behind all the other inmates.

Module A's CCTV video footage showed that at approximately 4:18 a.m., Chavandocarlos, without anyone noticing, climbed up the metal hand railing, leaned forward, and flipped himself over the railing. The video shows he landed on the concrete floor below, with his head hitting the floor in

front of Tank Five (5). Several deputies and inmates described hearing a loud thump, turned back, and looked down to see Chavandocarlos on the floor.

OCSD Deputy E. Johnson immediately radioed for additional deputies and for medical staff to respond. Multiple OCSD deputies responded to the scene to assist with medical, scene safety, and to place the remaining inmates on the tier back into Tank 5. Deputy Johnson observed Chavandocarlos lying unconscious on his back with a pool of blood forming around his head. Deputy Johnson verified that Chavandocarlos was still breathing and had a pulse.

OCSD Deputy T. Cook responded to the scene and saw that Chavandocarlos was bleeding from his head and elbow. He, too, found that Chavandocarlos was still breathing and had a pulse, but was not responding to any questions. Meanwhile, Deputy G. Schoeman grabbed a towel and white T-shirt from an inmate in the dorms to place under Chavandocarlos' head for support and to prevent blood from spreading.

At approximately 4:21 a.m., Orange County Fire Authority (OCFA) paramedics were dispatched to provide medical aid to Chavandocarlos. At the same time, three jail medical staff members arrived to Chavandocarlos and assumed medical care of Chavandocarlos from the deputies. As part of their treatment, jail medical staff established an Intravenous (IV) line and placed a Cervical Collar (C-Collar) on Chavandocarlos to stabilize his neck and back. During that time, he regained consciousness.

At approximately 4:41 a.m., OCFA paramedics took over care for Chavandocarlos from the jail medical staff. After their initial patient assessment, the OCFA paramedics found Chavandocarlos to have a laceration to the occipital area of his head, but he remained alert and his vital signs were stable. Additionally, paramedics determined that Chavandocarlos was able to move all extremities. Chavandocarlos told the OCFA paramedics he had not jumped from the second story tier of Tank Six (6) but that he had fainted while walking on the ground floor walkway of Tank Five (5). Due to the contradiction to what they had been told by deputies, paramedics noted this as a possible neurological deficit.

At approximately 4:45 a.m., the OCFA paramedics transported Chavandacarlos via ambulance to Orange County Global Medical Center (OCGMC). According to the OCFA paramedics, while en route to the hospital, Chavandocarlos was alert, maintained stable vital signs, had movement in all of his extremities, and remained adamant that he did not jump off of Tank Six (6) onto Tank Five (5), but said that he had fainted while walking on Tank Five (5). An OCSD deputy who accompanied Chavandocarlos in the ambulance believed that Chavandocarlos was incoherent and could not answer OCFA paramedics' questions about his current mental status or physical condition.

At approximately 4:57 a.m., the OCFA personnel relinquished Chavandocarlos' care to the OCGMC emergency room trauma staff. Chavandocarlos was still bleeding from the large laceration on the back of his head, which OCGMC staff stapled. OCGMC staff also stapled the laceration on Chavandocarlos' elbow. OCGMC staff asked Chavandocarlos what happened, and again he claimed that he had fainted. The staff also asked Chavandocarlos where he thought he was. Chavandocarlos did not immediately answer the question but eventually said that he was at a medical clinic getting his blood drawn. When a nurse asked Chavandocarlos the last thing he remembers, he could not answer the question and was mumbling his words, apparently unable to

complete a coherent sentence.

At approximately 5:13 a.m., OCSD deputies went into Tank Five (5) to search Chavandocarlos' property to look for anything that indicated a planned suicide attempt, such as notes or any writings. The deputies found nothing that revealed that Chavandocarlos planned to or wanted to try to kill himself.

At approximately 5:25 a.m., OCGMC staff performed a computed tomography (CT) scan on Chavandocarlos, which showed that he had a brain bleed and a fractured elbow. At around 7:00 a.m., Chavandocarlos had a seizure that lasted approximately twenty (20) seconds.

As a result of the incident, Chavandocarlos sustained a traumatic brain injury, subdural hematoma and extra-axial hemorrhages. His injuries required a craniectomy surgical procedure, which doctors performed to relieve intracranial pressure.

According to inmates acquainted with Chavandocarlos, Chavandocarlos did not display any signs of suicide. One inmate who was in close proximity to Chavandocarlos when he jumped said that he didn't really know Chavandocarlos but didn't know why he would do something like that. Another inmate who spent time with Chavandocarlos every day stated that Chavandocarlos looked depressed for 2-3 days before his suicide attempt, but had not mentioned anything about wanting to hurt himself. Another inmate who was close friends with Chavandocarlos said that Chavandocarlos had seemed "normal" the day before his suicide attempt, and said that he was "caught off guard" by Chavandocarlos' jumping off the top tier.

On October 9, 2020, OCSD released Chavandocarlos from their custody due to his medical condition. Chavandocarlos remained at OCGMC for continued medical care, but his condition worsened over the next few months.

On February 9, 2021, OCGMC transferred Chavandocarlos to Country Villa Plaza Convalescent Center. While there, Chavandocarlos' condition further deteriorated.

On March 9, 2021, at approximately 2:30 a.m., a doctor pronounced Chavandocarlos deceased at the Country Villa Plaza Convalescent Center. According to a working copy of a death certificate authored by that doctor, Chavandocarlos' cause of death was cardiac arrest, acute chronic respiratory failure, chronic stroke with left hemiparesis, and suicide attempt. Chavandocarlos' family arranged for a local mortuary to take Chavandocarlos' body and prepare it for burial.

On March 18, 2021, a mortuary death certificate clerk submitted the report of death to the Orange County Health Care/Recorders Office for recording purposes. During the review process, Orange County Health Care noted the attempted suicide.

On or about March 22, 2021, Orange County Health Care reported the circumstances to the Orange County Coroner's Office (OCCO), who initiated an investigation that revealed Chavandocarlos had attempted suicide while incarcerated at Orange County Jail, which commenced the custodial death protocol.

On March 25, 2021, Traditional Funeral Services transported Chavandocarlos' body from the mortuary facility to the Orange County Sheriff-Coroner Forensic Science Center.

EVIDENCE COLLECTED

The following items of evidence were collected and examined:

- Fifty-nine (59) post mortem digital photographs
- Orange County Crime Lab toxicological exam
- Orange County Sherriff-Coroner autopsy report
- Orange County Central Jail's Module A CCTV video footage
- One (1) jail issued pants
- One (1) jail issued underwear
- Injury photographs
- Audio recording of OCDASAU investigator interview with an Orange County Fire Authority (OCFA) paramedic
- OCFA patient care report
- Country Villa Plaza Nursing Center medical records
- Anaheim Global Medical Center medical records
- Orange County Social Services Agency medical records
- Orange County Health Care Agency (OCHCA) medical records
- Orange County Sheriff's Department investigative reports

AUTOPSY

On April 1, 2021, Independent Forensic Pathologist Dr. Scott Luzi conducted the post-mortem examination of Chavandocarlos' body at the Orange County Sheriff-Coroner Forensic Science Center. Dr. Luzi noted prior skull damage from an apparent craniectomy but found no other significant trauma to Chavandocarlos' body. The cause of death was pending review of medical records, toxicology, and examination of microbiological slides. An OCCL forensic specialist took forty-six (46) digital photographs.

On October 18, 2021, Dr. Luzi issued an amendment to his report, which identified the cause and manner of Chavandocarlos' death. The cause of death was determined to be complications of blunt force injuries to the head. Also noted was the additional condition of pneumonia. The manner of death was determined to be suicide.

Other relevant autopsy findings are as follows:

- **Major Injuries:**
  - None
- **Minor Injuries:**
  - None
- **Natural disease and pre-existing conditions:**
  - Remote internal fixation, thoracolumbar spine
  - Remote internal fixation, left ulna
  - Status post craniectomy
  - Cerebral edema
  - Pulmonary congestion and edema
  - Cardiomegaly

- Mild coronary atherosclerosis
- Moderate peripheral atherosclerosis
- Nephrosclerosis

EVIDENCE ANALYSIS

Toxicological Examination

A sample of Tomas Chavandocarlos' postmortem blood yielded the following results:

DRUG	MATRIX	RESULTS & INTERPRETATIONS
Methanol	Brain	248 ± 20 mg/dL
Alkaline Drugs	Liver	None Detected
Ethanol/Volatiles	Brain	Detected

BACKGROUND INFORMATION

Tomas Chavandocarlos had a State of California Criminal History record that revealed arrests for the following violations:

- Drunk Driving on Highway
- Drive without License
- Burglary
- Grand Theft Vehicle
- False Identification to Peace Officer
- Take Vehicle without Owner Consent
- Receive Known Stolen Property
- Possess/MFG/Sell Dangerous Weapon
- Contempt: Disobey Court Order
- Carry Loaded Firearm in Public Place
- Oral Copulation: Victim Under 10
- Continuous Sexual Abuse of Child
- Oral Copulation with Person Under 18
- Illegal Entry into the United States
- Alien Smuggling

THE LAW

Homicide is the killing of one human being by another. Murder, voluntary manslaughter, and involuntary manslaughter are types of homicide. To prove that a person is guilty of murder, the following must be proven:

a. The person committed an act that caused the death of another person;
b. When the person acted he/she had a state of mind called malice aforethought; and
c. He/she killed without lawful excuse or justification.

There are two kinds of malice aforethought, express malice and implied malice. Express malice is when the person unlawfully intended to kill. Implied malice requires that a person intentionally

committed an act, the natural and probable consequences of the act were dangerous to human life, at the time he acted he knew his act was dangerous to human life, and he/she deliberately acted with conscious disregard for human life.

A person can also commit murder by his/her failure to perform a legal duty, if the following conditions exist:

a. The killing is unlawful (*i.e.*, without lawful excuse or justification);
b. The death is caused by an intentional failure to act in a situation where a person is under a duty to act;
c. The failure to act is dangerous to human life; and
d. The failure to act is deliberately performed with knowledge of the danger to, and with conscious disregard for, human life.

A person can also commit involuntary manslaughter by failing to perform a legal duty, if the following conditions exist:

a. The person had a legal duty to the decedent;
b. The person failed to perform that legal duty;
c. The person's failure was criminally negligent; and
d. The person's failure caused the death of the decedent.

In *Giraldo v. California Dept. of Corrections and Rehabilitation* (2008) 168 Cal.App.4th 231, 250-251, the court held that there is a "special relationship" between jailer and prisoner:

> "[T]he most important consideration 'in establishing duty is foreseeability.' [citation] It is manifestly foreseeable that an inmate may be at risk of harm.... Prisoners are vulnerable. And dependent. Moreover, the relationship between them is protective by nature, such that the jailer has control over the prisoner, who is deprived of the normal opportunity to protect himself from harm inflicted by others. This, we conclude, is the epitome of a special relationship, imposing a duty of care on a jailer owed to a prisoner, and we today add California to the list of jurisdictions recognizing a special relationship between jailer and prisoner."

California Government Code 845.6 codifies that the special relationship that exists in a custodial setting gives rise to a legal duty, as follows:

> "[A] public employee, and the public entity where the employee is acting within the scope of his employment, is liable if the employee knows or has reason to know that the prisoner is in need of immediate medical care and he fails to take reasonable action to summon such medical care."

Criminal negligence involves more than ordinary carelessness, inattention, or mistake in judgment. A person acts with criminal negligence when he acts in a reckless way that creates a high risk of death or great bodily injury and a reasonable person would have known that acting in that way would create such a risk. In other words, a person acts with criminal negligence when the way he acts is so different from how an ordinarily careful person would act in the same situation that his or her act amounts to disregard for human life or indifference to the consequences of that act.

An act causes death if the death is the direct, natural, and probable consequence of the act and the death would not have happened without the act. A natural and probable consequence is one that a reasonable person would know is likely to happen if nothing unusual intervenes.

There may be more than one cause of death. An act causes death only if it is a substantial factor in causing the death. A substantial factor is more than a trivial or remote factor; however, it does not need to be the only factor that causes the death.

LEGAL ANALYSIS

There is no evidence of express or implied malice on the part of any OCSD personnel or any inmates or other individuals under the supervision of the OCSD. Accordingly, the only possible type of homicide to analyze in this situation is murder or manslaughter under the theory of failure to perform a legal duty.

Although the OCSD owed Tomas Chavandocarlos a duty of care, the evidence does not support a finding that this duty was in any way breached -- either intentionally (as required for murder) or through criminal negligence (as required for involuntary manslaughter).

When Chavandocarlos was booked into Orange County Central Jail, Orange County Health Care Agency (OCHCA) medical and mental health professionals screened Chavandocarlos to determine if he had any inclinations of self-harm. Chavandocarlos indicated that he never wanted to harm himself in the past and made no claims that he desired to do so presently or in the future. Chavandocarlos further claimed that he did not have any mental health conditions or take any medications that may have signaled a possible suicide attempt in the future.

Throughout his time in Orange County Central Jail under Orange County Sheriff's Department (OCSD) custody, Chavandocarlos never showed signs of potentially harming himself. Chavandocarlos submitted six medical slips to see OCHCA staff concerning his medical problems, such as back pain, toothaches, and headaches. These slips had a box for an inmate to check if he had thoughts of suicide, depression, or anxiety, which Chavandocarlos never selected. OCHCA staff that saw Chavandocarlos never made any indication that he said anything about self-harm or having mental problems. OCSD deputies who investigated Chavandocarlos' room found no evidence of any desire for self-harm.

Those around Chavandocarlos during his time in OCSD custody saw no signs that Chavandarlos would ever harm himself. Chavandocarlos' booking officer, OCHCA medical professionals, and even inmates close to Chavandocarlos stated he showed no suicidal tendencies and made no statements to suggest that he might be so inclined.

Without Chavandocarlos showing signs that he might be a potential suicide risk, OCSD could not be expected to take special precautions to monitor or help Chavandocarlos in a manner that might circumvent such suicide attempts. Therefore, OCSD did not fail to perform a duty when it did not anticipate that Chavandocarlos would attempt suicide.

Given their lack of knowledge to Chavandocarlos' state of mind, OCSD also did not fail to perform a duty when deputies had Chavandocarlos line up on a second tier with the other Tank Five (5) inmates to receive his sack lunch on the morning of September 2, 2020. Furthermore, the OCSD practice of lining up inmates to receive sack lunches was not an inherently or particularly

dangerous activity. The walkway was in full view of dozens of other inmates and was even in front of other inmate cells. Inmates and deputies alike expressed shock after Chavandocarlos threw his body from the second tier to the lower level, demonstrating that this was a surprise to all who witnessed it, not something that he had disclosed to others he may be inclined to do. Thus, no OCSD staff can be said to have breached their duty of care owed to Chavandocarlos while he was in their custody.

Furthermore, while in OCSD custody, Chavandocarlos consistently received adequate care to ensure his well-being. OCHCA staff provided him with prescription medications to treat his teeth, back, and head pain, and conducted multiple medical examinations like a lab test and dental exam to ensure he was in good health. OCHCA staff also carried out a dental procedure with Chavandocarlos' consent to remove teeth remnants that caused him pain.

Most importantly, OCSD deputies took immediate action after Chavandocarlos' suicide attempt. OCSD deputies instantly called for medical assistance, provided Chavandocarlos medical attention within minutes, and assisted in having him transported to the hospital, where he arrived approximately thirty minutes after his suicide attempt. According to Dr. Scott Luzi's autopsy, the blunt force trauma that resulted from Chavandocarlos jumping off of the Tank Six (6) walkway railing caused Chavandocarlos' death. There were no complications due to inaction. OCSD personnel acted swiftly, providing immediate medical assistance, and acted in a manner consistent with their duty of care. Thus, Chavandocarlos' death cannot be attributed to any malice or a failure to perform a duty by the OCSD.

OCSD personnel took immediate action after being alerted to Chavandocarlos' suicide attempt. Chavandocarlos jumped over the Tank Six (6) railing at approximately 4:18 a.m. Within seconds, OCSD deputies radioed medical staff and paramedics to provide Chavandocarlos medical assistance and subsequently tended to him themselves. By 4:21 a.m., paramedics were dispatched and jail medical staff personnel were caring for him. By 4:41 a.m., paramedics arrived, and by 4:57 a.m., Chavandocarlos was at the hospital in the care of its doctors and nurses. Therefore, OCSD's medical response did not contribute to Chavandocarlos' ultimate death. Dr. Luzi confirmed in Chavandocarlos' autopsy report that his death was solely the result of the injuries he sustained in attempting to take his own life.

Thus, there is no evidence to support a finding that any OCSD personnel or any individual under the supervision of the OCSD failed to perform a legal duty.

CONCLUSION

Based on all the evidence provided to and reviewed by the OCDA, and pursuant to applicable legal principles, it is our conclusion that there is no evidence to support a finding that any OCSD personnel or any individual under the supervision of the OCSD failed to perform a legal duty causing the death of Tomas Chavandocarlos. The evidence shows that Tomas Chavandocarlos died as a result of blunt force injuries of the head and that the death was a suicide.

Accordingly, the OCDA is closing its inquiry into this incident.

Respectfully submitted,

DEVIN CAMPBELL
Deputy District Attorney
TARGET/Gang Unit

Read and Reviewed by **BRETT BRIAN**
Assistant District Attorney
Special Prosecutions Unit

Read and Approved by District Attorney **TODD SPITZER**